FLORIDA DEPARTMENT OF CORRECTIONS
OFFICE OF HEALTH SERVICES

RISK ASSESSMENT FOR THE USE OF CHEMICAL RESTRAINT AGENTS AND ELECTRONIC IMMOBILIZATION DEVICES

DC4-650B *Risk Assessment for the Use of Chemical Restraint Agents and Electronic Immobilization Devices* must be completed when a preconfinement health assessment is conducted. DC4-650B will be reviewed at the time of all practitioner health care encounters. If any changes in an inmate's medical condition are identified (e.g., new diagnosis) that would affect the use of chemical restraint agents or electronic immobilization devices, a new DC4-650B must be completed and provided to security staff, replacing the previous DC4-650B. The results of this assessment should not be interpreted as approval or disapproval of the intended use of such agents/devices but rather an assessment of any risk factors.

Chemical Restraint Agents Assessment:

☐ At the time of this preconfinement health assessment, based on a review of the medical record, this inmate has no known medical conditions* that would be exacerbated by the use of chemical restraint agents.

☐ At the time of this preconfinement health assessment, based on a review of the medical record, this inmate **has** been identified as having a medical condition* that may be exacerbated by the use of chemical restraint agents.

*Conditions that may be exacerbated by the use of chemical restraint agents include, but are not limited to, the following: asthma, chronic obstructive pulmonary disease, emphysema, congestive heart failure, angina, pregnancy, and **unstable** hypertension. (Inmate is considered stable if B/P has been < 160/110 at last cardiovascular clinic visit.) Clinician recommendation ☐ Approve Use of Chemical Restraint Agents ☐ Disapprove Use of Chemical Restraint Agents

Florida State Prison (FSP) AND Union Correctional Institution (UCI) ONLY: Mental Health Alert Re: Chemical Restraint Agents Assessment

☐ At the time of this preconfinement assessment, based on a review of the mental health record, this inmate was discharged on the date of _____ from an inpatient mental health treatment unit (Crisis Stabilization Unit, Transitional Care Unit, or Mental Health Treatment Facility), within the ninety day period immediately prior to this placement in close management at FSP or UCI, indicating the need for the use of Crisis Intervention Team intervention techniques by the appropriate security staff prior to application of chemical agents, for the first ninety days following the above-referenced discharge date.

☐ The inmate was referred by mental health staff to inpatient care (Crisis Stabilization Unit, Transitional Care Unit, or Mental Health Treatment Facility) on the date of _____ while in close management at FSP or UCI, indicating the need for the use of Crisis Intervention Team intervention techniques by the appropriate security staff while the inmate is housed in an outpatient setting and is awaiting transport to the inpatient unit as a result of such referral.

Electronic Immobilization Device (EID) Assessment:

☐ At the time of this preconfinement health assessment, based on a review of the medical record, this inmate has no known medical condition* that may be exacerbated by the use of electronic immobilization devices.

☐ At the time of this preconfinement health assessment, based on a review of the medical record, this inmate **has** been identified as having a medical condition* that may be exacerbated by the use of electronic immobilization devices.

*Conditions that may be exacerbated by the use of electronic immobilization devices include, but are not limited to, the following: seizure disorder, multiple sclerosis, muscular dystrophy, pacemaker, and pregnancy.

Clinician recommendation ☐ Approve Use of EID ☐ Disapprove Use of EID

Clinician's Name _____ Date _____ Time Notified _____

_____ _____

Staff Signature/Stamp (Person Completing Form) Date

Inmate Name_____
DC#_____Race/Sex_____
Date of Birth_____
Institution_____

Distribution: Original—to be maintained with medical record
White copy—to be maintained with DC6-229 in the housing unit

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Clinician's Name _____ Date _____ Time Notified _____

_____ _____

Staff Signature/Stamp (Person Completing Form) Date

Security Copy

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DC#_____Race/Sex_____
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